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Notice of Independent Review Decision

September 10, 2012

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:
Lateral release surgery- right knee arthroscopy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:
Board certified orthopedic surgeon

REVIEW OUTCOME:
Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:
☒ Upheld (Agree)

Provide a description of the review outcome that clearly states whether medical necessity exists for each of the health care services in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:
TDI
- Reviews (07/27/12, 08/07/12)

M.D.
- Diagnostics (10/06/11, 03/06/12)
- Office visits (10/14/11 - 08/08/12)
- Procedures (11/03/11, 07/12/12)

Inc.
- Diagnostics (10/06/11, 03/06/12, 03/22/12)
- Procedures (11/03/11, 04/19/12)
- Office visits (05/02/12 - 07/23/12)

PATIENT CLINICAL HISTORY [SUMMARY]:
The patient is a male had a dolly in his hand when a person walked in front of him. He tried to avoid hitting the person with the dolly and while doing so, twisted his right knee on xx/xx/xx.
2011: On October 6, 2011, magnetic resonance imaging (MRI) of the right knee revealed large displaced bucket-handle tear of the medial meniscus and joint effusion with fluid in the popliteus sheath.
On October 14, 2011, M.D., evaluated the patient for right knee swelling, difficulty with ambulation due to inability to fully straighten the knee and loss of motion. The patient felt that his knee was unstable. Dr. noted that the patient was initially seen by Dr. and was treated with physical therapy (PT) and a brace. Examination

of the right knee showed tenderness at the medial joint line, some knee effusion, decreased range of motion (ROM) and positive McMurry. Dr. assessed bucket handle tear of the medial meniscus.

On November 3, 2011, Dr. performed right knee arthroscopy, examination under anesthesia (EUA), excision of the medial meniscus tear and debridement of the chondromalacia of the medial tibial plateau. Postoperatively, the patient was recommended PT and weightbearing as tolerated. The patient reported overall improvement.

2012: In January, Dr. noted that the patient was not feeling strong enough to resume his normal occupation. He referred the patient for a functional capacity evaluation (FCE) and work conditioning.

On follow-up, Dr. noted that in an FCE performed on January 12, 2012, work conditioning program (WCP) was recommended.

In February, Dr. noted that the patient had completed seven sessions of (WCP). Examination revealed quadriceps atrophy. There was no calf tenderness or ankle edema and range of motion (ROM) was almost full. His right quadriceps strength was 75% and right hamstring strength was 90%. The patient was released to full duty and was given an appointment to see Dr. for an impairment evaluation on February 16, 2012.

On March 5, 2012, Dr. noted that the patient had failed a pre-employment testing. Dr. recommended proceeding with further work conditioning as recommended by Physical Therapy.

On March 6, 2012, MRI of the right knee showed following findings: (1) Status post medial meniscus repair. The signal change in the posterior horn was either a postoperative change or a small shallow under surface tear. (2) Mild chondromalacia at the patellofemoral and medial femorotibial compartments. (3) Joint effusion with tiny Baker's cyst. (4) Scarring in Hoffa's fat pad.

On follow-up, the patient reported instability and repeated giving out of the knee. Dr. recommended a formal testing of laxity with a KT 1000 ligament test and possible repeat knee arthroscopy.

On March 22, 2012, KT 1000 test showed that the involved right knee double the movement compared to the uninvolved left and this correlates with an ACL test that showed moderate laxity.

On follow-up, Dr. reviewed the test findings which showed that the patient had double laxity on the right knee. Examination showed anterior instability on the right knee. Dr. recommended right knee arthroscopy, EUA and anterior cruciate ligament (ACL) reconstruction.

On April 19, 2012, Dr. performed right knee arthroscopy, EUA and excision of medial meniscus tear and reconstruction of the ACL with autograft patellar tendon.

On postoperative follow-ups in April and May, the patient was maintained on Ultram, PT and home exercise program (HEP). Dr. noted that the patient had pain at his kneecap. He recommended the patient to switch from knee immobilizer to a hinged brace.

In June, Dr. noted that the patient had ongoing knee pain. His physical therapist was not able to try McConnell taping. Examination showed pain on terminal extension when the patient performed a straight leg raise (SLR) independently. Dr. recommended continuing home exercise, PT and use of brace. On follow-up, the patient was released to restricted duty.

On July 9, 2012, Dr. advised against getting an ACL brace until the patient had recovered more muscle mass at the quadriceps. He recommended progression in exercises. On follow-up, Dr. opined that the patient needed a patellar taping.

On July 23, 2012, Dr. noted that the patient's flexion was to 130 degree and extension was full. The patient had two visits remaining of the therapy. He was not able to progress with strengthening due to pain at the patella on full extension. Examination showed that the patient could perform SLR independently but had pain on terminal extension. There was notable muscle atrophy particularly while comparing the left and right quadriceps. Dr. opined that the patient would not regain his quadriceps strength because of his patellar-tracking problem. Dr. recommended finishing PT and right knee arthroscopy, EUA and lateral release.

Per utilization review dated July 27, 2012, the request for right knee arthroscopy EUA and lateral release was denied with the following rationale: "*The request for repeat arthroscopy in this particular setting cannot be considered reasonable or medically necessary. The claimant has had two previous surgeries in the last seven months including anterior cruciate ligament (ACL) reconstruction and subsequent arthroscopic debridement. The records provided do not make a compelling case that this claimant truly has some type of extensor malalignment that would benefit from arthroscopic lateral release. The mere fact that they have persistent pain complaints in the patellofemoral joint would not itself make the claimant a good candidate for arthroscopic lateral retinacular release at this juncture. Thus, without further information and a better handle on the claimant's clinical complaints, the request cannot be considered reasonable or medically necessary in this setting.*"

On July 30, 2012, Dr. noted that the request for the surgery was denied. He opined that the patient had worked diligently at his quadriceps rehabilitation and had tried taping. The patient had not responded to a conservative management. Dr. opined that the patient needed surgery to be performed before going forward

for work conditioning due to his patellar tracking problem. The request for surgery was resubmitted.

Per reconsideration review dated August 7, 2012, the request for right knee arthroscopy EUA and lateral release was denied with the following rationale: *"The request is not certified. This is an appeal for right knee arthroscopy examination under anesthesia and lateral release that was previously not certified on July 27, 2012, by Dr. as the claimant has had two previous surgeries in the last seven months including anterior cruciate ligament reconstruction and subsequent arthroscopy debridement. The records provided do not make a compelling case that this claimant truly has some type of extensor malalignment that would benefit from arthroscopic lateral release. The mere fact that an individual has persistent pain complaints of the patellofemoral joints would not itself make the patient a good candidate for arthroscopic lateral retinacular release at this juncture, thus without further information and a better handle on the claimant's clinical complaints the request cannot be considered reasonable and medically necessary in this setting. The only additional medical records provided for review is the utilization review determination dated July 27, 2012, with reasons for previous non-certifications, there were no other medical records provided for the appeal. The previous non-certification is supported as the guidelines indicate that conservative care must be exhausted. There must be objective clinical findings including pain and functional limitations despite conservative care. There must be subjective complaints including knee pain with sitting or patellofemoral movement, recurrent dislocations, lateral tracking of the patella, patella apprehension and increase Q angle and there must be abnormal imaging indicating a patella tilt on X-rays, computed tomography or MRI. The MRI provided for review from March 6, 2012, did not document that there is any abnormal patellar tilt on the MRI. Based upon the medical documentation provided for review and the peer reviewed evidenced based guidelines persistent pain complaints and patella femoral joint again as Dr. noted in his previous non-certification would not itself make the claimant a good candidate for arthroscopic lateral retinacular release. There is no imaging that demonstrated any type of abnormal patella tilt. Clinical note from July 23, 2012, reported that the claimant continued to improve with motion and pain based upon the examination that was provided on that date. There was no documentation of patella apprehension, lateral tracking of the patella, synovitis with or without crepitus or increased Q angle. The documentation noted that things were continuing to improve, but the claimant did have some ongoing patellofemoral pain complaints. Based upon this fact the request for appeal for right knee arthroscopy examination under anesthesia and lateral release is not medically supported by the Guidelines."*

On August 8, 2012, Dr. noted that surgery was again denied. He explained the patient about the options he had and provided the number to office of injured employee council.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS, AND CONCLUSIONS USED TO SUPPORT THE DECISION:

I have carefully reviewed the files as it pertains to determine the medical necessity of lateral release on this claimant's right knee in connection with the vocational related injury of xx/xx/xx.

This case had been reviewed on two separate occasions both reviewers appear to be in agreement that the claimant failed to have objective findings on examination that would conclusively identify the patellofemoral joint and in particular extensor malalignment as being the ultimate source of the claimant's pain complaints. As such both reviewers recommended no surgery in that setting.

Unfortunately there is limited additional information from Dr.. Other than Dr. comments that the claimant continues to have persistent patellofemoral complaints in spite of conservative measures, the file lacks the objective findings that would support Dr. assessment of the claimant's subjective complaints, is that the patellofemoral joint remains the source of the claimant's problems. Without that information the request would not be considered reasonable and medically necessary. Of note other options such as corticosteroid injections and/or an additional knee brace would also be viable in efforts to try and more conclusively identify the location of the claimant's pain. That said would support both the physician reviewers assessments that the information provided in this file is insufficient to recommend the treatment as being reasonable and medically necessary.

If the claimant's subsequent medical records include thorough physical examination that document a persistent atrophy, objective evidence of extensor malalignment and other signs such as apprehensive signs the claimant may in fact be a reasonable candidate for the proposed surgery but that information is lacking in this case and thus I would support the previous adverse determinations.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

☒ **ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES**

Official Disability Guidelines Treatment in Worker's Comp, 17th edition, 2012 Updates, chapter knee

Lateral Retinacular Release

ODG Indications for Surgery™ -- Lateral retinacular release:

Criteria for lateral retinacular release or patella tendon realignment or maquet procedure:

1. Conservative Care: Physical therapy (not required for acute patellar dislocation with associated intra-articular fracture). OR Medications. PLUS

2. Subjective Clinical Findings: Knee pain with sitting. OR Pain with patellar/femoral movement. OR Recurrent dislocations. PLUS

3. Objective Clinical Findings: Lateral tracking of the patella. OR Recurrent effusion. OR Patellar apprehension. OR Synovitis with or without crepitus. OR Increased Q angle >15 degrees. PLUS